NABH NABL No.1

9620770750

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mr.SUDHEENDRA B N**	**UHID**	**: UHJA24001029**
Age / Sex	: 77 Years / Male	OP NO/Reg Dt	: 29-04-2024 09:04 AM
Spouse / Father Name	: VATHSALA	Department	:
Address	: BANNERGHATA ROAD VIJAYA BANK LAYOUT BLR, , Bengaluru Urban,	Refered By	: Dr. Raghavendra Aralah
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

— As part of AHC

— on URINATX since 8yr.

HT - 157 cm
WT - 48 kg
SpO_2 - 98%
PR - 72 b/m
BP - 147/84 mmHg

Investigations: — wales as a CA

NO DM/HTN

HbA1C - 5.5

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

- Urine c/s
- Consult UROLOGIST

KOTARY crane

Signature of the Doctor

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Address	: BANNERGHATA ROAD VIJAYA BANK LAYOUT BLR, , Bengaluru Urban,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Shwetha. (optho)

Complaints / Findings / Observations :

V/A (fnf) 6/9p 6/9p } N6. nil systemic

Investigations:

M/S OU Cataract (+)

Treatment / Care of Plan / Provisional Diagnosis : Fndis: OU CDR 0.3 bot L:1 FM (+) (undilated)

Injn: OU Cataract.

Follow Up Advice :

Dilated fundus examination

Signature of the Doctor

29/4/24

DEPARTMENT OF RADIODIAGNOSIS

Name	Sudeendra B N	**Date**	29/04/24
Age	77 years	**Hospital ID**	UHJA24001029
Sex	Male	**Ref.**	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- **No radiographic abnormality.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

Patient name :	Mr. SUDHEENDRA B N	Date :	29/04/24
Age :	77 years GENDER: MALE	Patient ID :	24001029
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.7 (2.5-3.7)	LVIDD : 4.8 (3.5-5.5)	MV EV : 60.1	AV : 82.5	MR : MILD MR
LA : 3.1 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 96.4		AR : NORMAL
RA : 2.5 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 82.0		PR : NORMAL
RV : 2.4 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ----	AV : ----	TR : MILD TR
TAPSE: 1.8 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : GRADE 1 LVDD		
	LVPWS : 1.0 (0.9-1.2)			
	EF : 60%			

DESCRIPTIVE FINDINGS

Left Ventricle	: NORMAL
Right Ventricle	: NORMAL
Left Atrium	: NORMAL
Right Atrium	: NORMAL
Wall motion analysis	: NO RWMA
Mitral Valve	: NORMAL
Aortic Valve	: TRILEAFLETS & THICKENED
Tricuspid Valve	: NORMAL
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL AND COLLAPSING

IMPRESSION:

SCLEROTIC AORTIC VALVE
NORMAL LV SYSTOLIC FUNCTION EF : 60%
GRADE 1 LV DIASTOLIC DYSFUNCTION
MILD MR, TR, PASP-30mmHg
NO PULMONARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

ID:24001029
Name:MR SUDHEENDRA

29-Apr-2024 AM9:36:26

ex:M Birth date: 77 years

cm kg / mmHg

edication:

ymptoms:

istory:

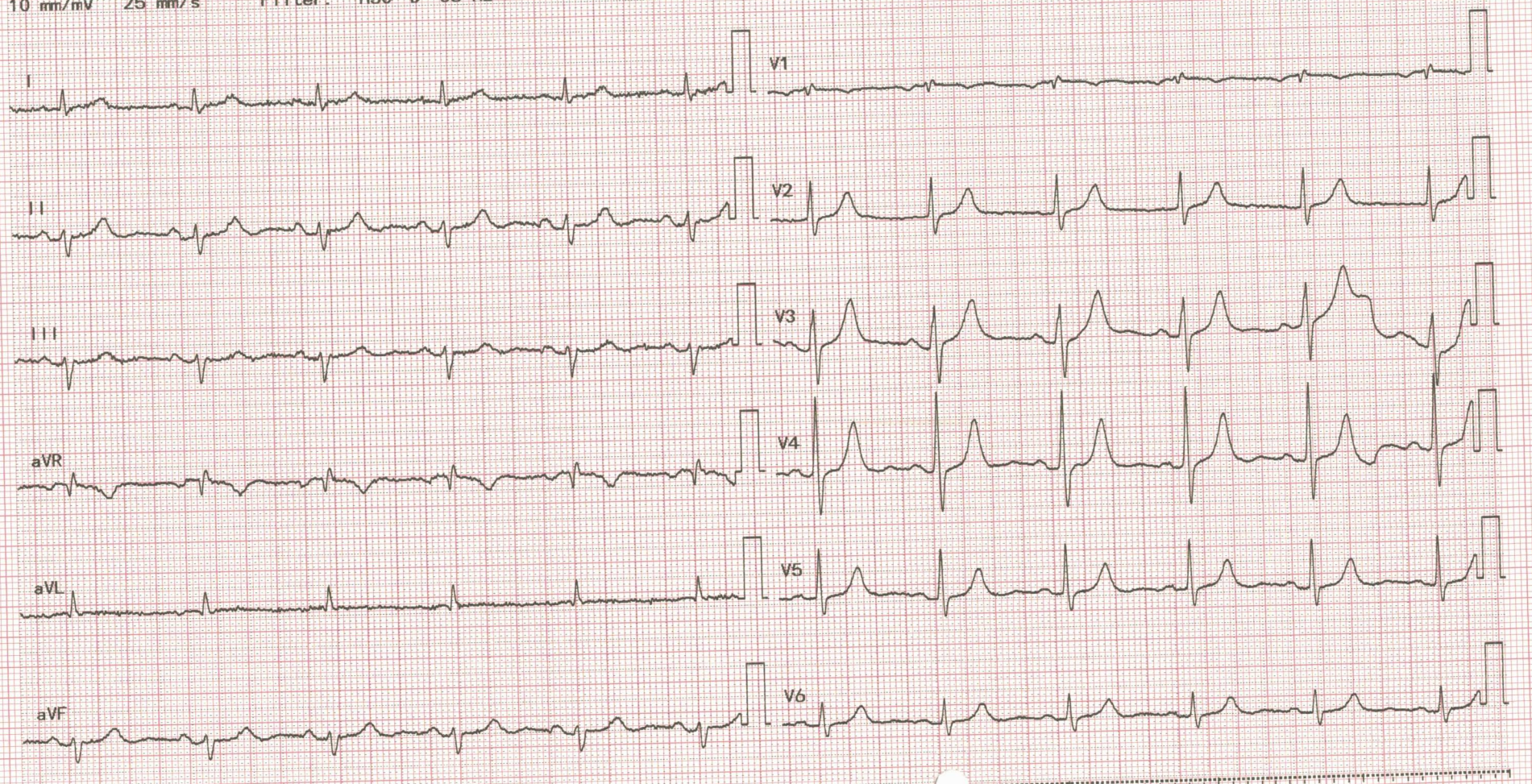
ent. rate	71	bpm
R int	164	ms
RS dur	90	ms
T/QTc(E) int	388/ 411	ms
/QRS/T axis	90/ -33/ 61	°
V5/SV1 amp	0.93/ 0.13	mV
V5+SV1 amp	1.07	mV

1100 Sinus rhythm
2420 RSR (QR) in lead V1/V2, consistent with right ventricular conduction delay [RSR pattern (V1)]
7200 Abnormal left axis deviation [-90 deg. < QRS axis < -30 deg.]
0102 ARTIFACT PRESENT
9130 ** borderline ECG **

Unconfirmed Report
Reviewed by:

10 mm/mV 25 mm/s Filter: H50 D 35 Hz

10 mm/mV



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

RE: +1.50 DS / -1.00 x 80. 6/9P

LE: +2.00 DS / -0.50 DC x 140 6/9P

BE Add +3.00 DS / d near M.

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DEPARTMENT OF RADIODIAGNOSIS

Name	Sudeendra B N	**Date**	29/04/24
Age	77 years	**Hospital ID**	UHJA24001029
Sex	Male	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and echopattern. No intra or extra hepatic biliary duct dilatation. No focal lesions. **Portal vein** is normal in caliber. **CBD** is not dilated.

Gall bladder is normal without evidence of calculi, wall thickening or pericholecystic fluid.

Pancreas - Visualized part of the pancreatic head and body appears normal in size, contour and echogenicity. Rest of the pancreas is obscured by bowel gas.

Spleen is normal in size, shape, contour and echopattern. No focal lesion.

Right Kidney is normal in size (9.1 x 2.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (7.8 x 3.7 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Retroperitoneum - Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

Urinary Bladder is well distended. ***Wall appears mildly thickened.*** No evidence of calculi, mass, mural lesion or clots.

Prostate is normal in echopattern and size, measures ~ 17.7 cc.

No ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.

IMPRESSION:

- **Mild urinary bladder wall thickening - of concern for cystitis.** *Suggested urine routine correlation.*
- **No other definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

UNITED HOSPITAL
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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. SUDHEENDRA B N	Order No	: 1000084191
UHID	: UHJA24001029	Registered On	: 29/04/2024 09:04:25 AM
Age/Sex	: 77/Years Male	Collected On	: 29/04/2024 09:17:32 AM
Ward / Bed No	:	Reported On	: 29/04/2024 01:00:42 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA240001341
Station	: At Hospital	Mobile No	: 9902971527
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	99	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	**141**	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.5	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	111.14	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.93	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	7.35	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.04	µIU/mL	0.38-5.33
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	137	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	51	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	**37.4**	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	89.4	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	10.19	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.6		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.3		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	99.6	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.4	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	14	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.98	mg/dL	0.8-1.3
BUN/CRE-RATIO (Method: Calculated)	14.2		12–20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.66	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.16	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.50	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.6	g/dL	6.6-8.3

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ALBUMIN (Method:BCG)	4.20	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.39	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.75		2:1
SERUM SGOT (Method:IFCC without P5P)	18	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	11	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	57	U/L	50-116
GGT (Method:IFCC)	11	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.97	ng/mL	< 4.0

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

UREA (Method:Urease GLDH - Kinetic)	28.9	mg/dL	17-43

Dr. Shobha Emmanuel
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CONSULTANT PATHOLOGIST
KMC:66136

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC) — Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	**12.99**	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	**39.5**	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	**3900**	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	61.44	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	28.02	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.49	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.57	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.48	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.54	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	86.9	fL	78-100
MCH (Method: Calculated)	28.6	pg	27-31
MCHC (Method: Calculated)	32.9	g/dL	31-37
RDW - CV (Method: Calculated)	13.8	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.59	Lakhs/Cum	1.5-4.5

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	**8.02**	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	15.3	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-20

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Method)	O	
Rh Factor (Method:Agglutination Method)	Positive	

Interpretation Notes

Note: Both forward and reverse grouping performed

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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.010		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Absent		Absent
KETONE BODIES (Method:Nitroprusside method/ Rothera's test)	Absent		Absent
BILIRUBIN (Method:DIAZO/FOUCHET'S TEST)	Negative		Negative
BILE SALT (Method:Hay's sulfur test)	Absent		Absent
NITRITE (Method:Griess method)	Positive		Negative
UROBILINOGEN (Method:Azo coupling method)	Normal		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Present (++)		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative
MICROSCOPIC EXAMINATION			

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	4-6	/HPF	0-5
PUS CELLS	10-15	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	BACTERIA PRESENT		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
PRAVEEN T

---End of Report---

Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

*NABL renewal under process.